SMA news

For Doctors, For Patients

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Associations and Societies: The Ties That Bind

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SHS: Beginnings & Purpose

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The Editors' Musings

DR TINA TAN

Editor

Dr Tan is a psychiatrist in private practice and an alumnus of Duke-NUS Medical School. She treats mental health conditions in all age groups but has a special interest in caring for the elderly. With a love for the written word, she makes time for reading, writing and self-publishing on top of caring for her patients and loved ones.

The writing of this Editorial comes on the heels of SMA's Annual General Meeting, where I was inducted into the 64th Council. It is a timely reminder that the advocacy work done by the SMA, and other medical associations in Singapore, is largely performed by doctors with passion and strong values, with a core group of dedicated staff backing us up. There are a number of such professional associations in Singapore, and each contributes in their own ways to the medical community, such as by setting local treatment and management guidelines, and harmonising practices with global developments.

On that note, our Feature article is written by past SMA President Dr Lee Pheng Soon, who talks about what SMA has done for the profession over the past few decades. We have also featured an article by Dr Low Lip Ping on the accomplishments of the Singapore Hypertension Society.

Every year, there is an attrition rate in membership due to Members who choose to leave SMA. Their reasons are understandable. Most state that they do not see any value in continuing membership. But Dr Lee has summed it up best in his article: "The record is clear – decade after decade, SMA has repeatedly stood up for the medical profession."

May this be an invitation for more to join SMA Membership and help us, so that we can better help our patients.

DR JIMMY TEO

Guest Editor

Dr Teo is an associate professor in the Department of Medicine, NUS Yong Loo Lin School of Medicine, and senior consultant in the Division of Nephrology at National University Hospital. He is an active member of the Singapore Society of Nephrology.

Birds of a feather flock together.

Upon graduation, the first association I joined was the SMA, believing that young doctors should join their professional societies or associations to keep abreast of issues that affect the profession and actively participate to have a collective voice. The SMA functions as a uniting assembly of medical students and doctors, representing the interests of doctors. Thus, given the dramatic changing landscape of professional practice in Singapore, I would encourage all newly graduated doctors to join the SMA as well.

In 2022, the Singapore Society of Nephrology (SSN) celebrated its 50th anniversary. It was made even more memorable as I was presented with the SSN Achievement Award! The year 2022 has been a demanding year for my family as we grappled with serious illness and major school examinations. Fortunately, I work with extremely kind people who pitched in to cover some of my duties and adjusted schedules for me to be away at times. The anniversary celebrations brought together friends in nephrology from all across Singapore and reunited many doctors and associates, present and retired. The SSN also had our friends from the Malaysian Society of Nephrology join us in our celebration. The reopening of the borders and resumption of overseas travel allowed many of us to renew our ties. Besides the SSN, another society which I am an active member of is the Singapore Hypertension Society (SHS). The SHS celebrated its 20th anniversary in 2022 with a dinner for all its members.

Many of us actively participate in different professional societies and associations. *SMA News* is happy to celebrate the remarkable anniversaries and milestones of the professional organisations founded and ran by fellow doctors, and to feature societies and associations that have anniversaries or are celebrating key events. We look forward to contributions! ◆

ADDRESSING WHAT A DOCTOR CANNOT DO ALONE

Text by Dr Lee Pheng Soon

Dr Lee Pheng Soon was first co-opted into the 33rd SMA Council (1992/1993) by Dr Giam Choo Keong. Dr Low Lip Ping (author of the Opinion article on page 14) was a fellow Council member. Dr Lee has continued as an elected Council member from the 34th Council to the present 64th Council. He was SMA President for three years, starting from the year of the SARS outbreak in 2003, and was the first doctor to attain 20, then 30 years of continuous service as an elected Council member. To mark his 30-year Long Service Award, *SMA News* invited Dr Lee to reflect on his experiences with the SMA, and share what he sees as the role of SMA in these rapidly changing times.

Dr Lee is from the fourth generation of doctors in his family. His maternal great-grandfather and his paternal grandfather were graduates of the 2nd (1911) and 9th (1918) cohorts of Singapore's Medical School. Their descendants served the SMA with distinction, including as former Presidents. Now retired from a career in Pharmaceutical Medicine, Dr Lee continues this tradition, serving the community as a HDB Family Physician, and the Medical Profession as a SMA Old-Timer.

The Ministry of Health (MOH) recognises more than 15,000 doctors and acknowledges three Professional Bodies: the Academy of Medicine, Singapore; the College of Family Physicians Singapore (CFPS); and the SMA. SMA was first set up in 1959, and its achievements have been well documented in its 60th anniversary issue (https://bit.ly/5105-Contents). Over these 65 years, different Presidents and Councils have had different visions for "what SMA means". The earliest vision is written in SMA's crest: "Jasa Utama" (Malay for "Service before Self"). In 2015, a new slogan was adopted, "For Doctors, For Patients", acknowledging SMA's expanded scope in society.

If you were to ask individual doctors, "What does SMA mean to you?", you would get many different responses. In this increasingly complex world, every doctor inevitably encounters situations where even his/her best efforts will be insufficient. In clinical matters, a doctor can refer to more specialised colleagues for advice, but in matters relating to the practice ecosystem, one can only turn to his/her professional body. In good causes affecting doctors and patients, where an individual doctor cannot do what is necessary for himself/herself, the SMA should stand in for him/her. I see this as SMA's duty, perhaps even its raison d'être.

I first witnessed this in real life in the field of medical indemnity 22 years ago, when the SMA President, Council members and its Honorary Legal Advisor battled to help 1,800 doctors in serious trouble – more serious than they perhaps even understood then.

When doctors meet trouble

Every doctor needs indemnity against malpractice. A/Prof Goh Lee Gan expressed it thus: "[T]here are the unavoidable mishaps that happen in medical practice. Things will happen, whether because of misadventure or bad luck. As the Chinese saying goes, 'If one were to go up the mountain often enough, one would meet the tiger.'"[1]

To this I would add: "As the doctor neither knows when he will meet the tiger, nor how ferocious the tiger will be, he needs a reliable partner who always has his back, and who carries enough bandages and a tourniquet for his wounds after the fight." In other words, malpractice indemnity for the doctor must be good and reliable, and should provide uninterrupted cover – from the first day of work as a house officer, till the expiry of the statute of limitations years after he/she has retired.

When Singapore doctors suddenly lost protection

In real life, doctors can only do three things regarding indemnity: choose their indemnity provider, pay their premiums faithfully and pray nothing major goes wrong with their provider. But what happens when something major does happen? In 2002, I saw first-hand how one-third of Singapore's doctors were affected by the failure of their indemnity provider, how it left them helpless as individuals practising without cover, and how the SMA represented them to find a solution not available to themselves as individuals.

Until 1999, the two main providers in Singapore were Medical Defence Union (MDU) and Medical Protection Society (MPS), both based in the UK. In September 1999, MPS absorbed MDU's Singapore portfolio, when MDU withdrew from Singapore as part of a global reorganisation. To allow doctors a choice in future years, SMA President A/Prof Goh Lee Gan invited Australia's largest medical insurer, the 109-year-old United Medical Protection (UMP) to be a second indemnity provider in Singapore. Unexpectedly, UMP failed in 2002, and "a third of Singapore doctors (1,800 doctors) were left running for cover".[2]

The impact on these UMP-insured doctors was like a perfect storm: support for incidents already reported was suspended (though this was eventually honoured), incidents that had occurred but had not yet been reported ("IBNR") immediately had no cover, and doctors had to work without any indemnity cover. Even buying a new policy immediately would not provide cover for the gap between the end of UMP coverage and the start of the new policy (known as the "nose period"). This was really bad, and to some doctors with reported incidents or IBNR, it could amount to financial disasters.

No doctor could do anything about these body blows as an individual. I know; I was one of them.

SMA steps in to help

As an organisation, SMA had resources and connections that allowed it to attempt efforts not available to individuals. After confirming that neither the MOH nor Ministry of Foreign Affairs were in a position to help, SMA sent Dr Wong Chiang Yin (who was already in Australia for other reasons) to meet with UMP management to clarify the precise position that Singapore doctors were in. It was not good.

Then, "on 2 May, the SMA Council, at an extraordinary Council Meeting, decided to be proactive and to look for alternative cover. So, directions were given to talk to two parties – MPS and NTUC Income. Dr Lee Pheng Soon spearheaded the MPS venture and asked for prospective and nose covers. A/Prof Goh [Lee Gan] spearheaded the venture with NTUC Income, and held discussions with Mr Tan Kin Lian, CEO of NTUC Income, about providing medical indemnity cover for doctors."[1]

In the event, MPS generously extended nose coverage without additional cost, and the many former UMP-covered doctors who took up MPS membership were immediately covered prospectively and retrospectively. NTUC Income offered lower-priced claims-made policies to doctors. This resolution pulled together by SMA was imperfect, but it left no doctor more exposed than before UMP's collapse, and it secured a future with adequate indemnity protection for the profession. In a dialogue session on 2 September 2002, SMA's Honorary Legal Advisor Mr Lek Siang Pheng remarked that, in terms of indemnity cover moving forwards, the situation of two available alternatives, namely MPS and NTUC Income, was similar to that in 1999. Twenty-one years later, I still remember him burning the midnight oil for months, supporting us.

Finally, in September 2005, UMP contacted 1,314 Singapore doctors and offered a pro-rated refund of their subscriptions in return for a deed of release. From then till now, SMA has continued to work at improving the quality of indemnity options available to Singapore doctors. One such effort included providing input to the eventual form of the present indemnity covering all doctors employed by Ministry of Health Holdings, currently run by insurance broker Marsh.

Other examples of SMA's contributions

Though it was dramatic and affected many doctors, the 2002 indemnity crisis was not the only instance where SMA, as an organisation, actively stepped in to support doctors when they struggled as individuals.

Some such instances recalled by fellow Council members, past and present, are shared in the table on the facing page.

There are many more situations where SMA had helped when individual doctors could do nothing. Some were futile situations where it was important just to put SMA's position on record. Nevertheless, I think it is fair to say that in the past 30 years, SMA has not been neglectful in this one area of work: stepping forward and doing things that individual doctors cannot do by themselves.

1994	▶ Formation of the Medical Officers' Committee, to better understand and represent junior doctors as a group.
2000	▶ Founding of the SMA Centre of Medical Ethics and Professionalism (CMEP), to teach medical ethics and champion ethical thinking. A dedicated Centre could showcase ethics as the spine of medical professionalism, and over the next 24 years, SMA CMEP would accomplish this in a way that individual doctors cannot in their daily work.
2000–2002	▶ SMA repeatedly spoke for the removal of the one-third quota imposed at that time on the intake of female medical students.
2003	▶ At the onset of the SARS outbreak, there was no national stockpile of personal protective equipment or N95 masks, and none were available for sale. SMA successfully sourced critically needed N95 masks for private sector doctors. Older GPs will remember the long queues of doctors patiently waiting for their allotment at the old SMA office. This was a life-saving luxury; the newspapers at that time carried many images of less-fortunate medical staff in other countries improvising face covers from surgical gauze. These queues were repeated recently during the epidemic phase of COVID-19, when SMA helped distribute free hand sanitiser provided by the Temasek Foundation, as well as selling batches of N95 and surgical masks from MOH stockpiles (together with CFPS).
2007	▶ The Medical Students' Assistance Fund was set up, following a survey of medical students' financial backgrounds. The SMA Charity Fund (SMACF) was later set up in 2013 to better raise funds and support needy medical students. It absorbed and took over the functions of the Assistance Fund. In 2022, the SMACF supported 51 students with bursaries totalling $255,000, and has to date disbursed 472 bursaries totalling more than $2.1 million.
2016	▶ Male Residents undergoing their National Service (NS) reservist stints found that this time away was included in their total days of absence from their medical training. This adversely affected their Residency performance. After SMA spoke to the Ministry of Defence and sponsoring institutions, NSmen were advised to notify ICT dates to their Programme Directors (PDs) earlier, to allow PDs to try arrange their schedules to avoid the need to remediate or repeat the affected posting.
2020	▶ Over 1,500 doctors had their practice details listed on a "medical concierge" website without their permission. Its management also pointedly ignored any individual doctor's protests. Following requests for help from doctors, SMA coordinated action that resulted in the company deleting this information.
2021	▶ SMA provided input in the forming of the Multilateral Healthcare Insurance Committee (MHIC), whose work has resulted in more equitable treatment of doctors and patients. Before the formation of the MHIC, individual doctors were powerless when they felt unfairly treated by insurance companies.
Ongoing	▶ The SMA Doctors-in-Training Committee advocates on behalf of junior doctors on topics such as work hours, career opportunities and remuneration. SMA is also represented on the MOH National Wellness Committee for Junior Doctors.
Ongoing	▶ SMA CMEP is preparing to offer modules in Medical Ethics and Professionalism, to enable doctors to earn Core Ethics continuing medical education points necessary from 2024 onwards.

Concluding thoughts

Every month, the SMA Council receives a few resignations from Members. The most common reason given is "I am not getting any value for my annual subscription."

There is a lot of truth in that. The annual subscription could be used for something else. For example, to a stressed-out doctor seeking entertainment, the SMA cannot possibly compete with 20 cinema tickets a year.

Even so, I urge all of us to change our mindset and think instead: it is not about what SMA can give me, the individual doctor, but it is about what SMA can do for ***all*** doctors when individuals are powerless. The record is clear – decade after decade, SMA has repeatedly stood up for the medical profession, especially when the individual doctor is helpless in the face of an unfair or unjust situation affecting either doctors or patients. Very bluntly put, it is a matter of SMA needing our support, rather than what we can get out of SMA for ourselves. So let us all stay engaged and help by supporting SMA's work silently or, better still, by participating actively. Remain in and recharge your SMA. Encourage your President and your Council members, as they continue working for doctors and for patients. And please never forget: if it is to continue doing more for everybody, the SMA needs **you**. ◆

References

1. Goh LG. The Inside Story of UMP Singapore. SMA News [Internet]. September 2002. Available at: https://bit.ly/3L0qkq8.

2. Tan HL. Doctors look for cover. TODAY. 5 July 2002. Available at: https://bit.ly/41TPGgi.

A Thousand Miles and Beyond

Text by Dr Tan Yia Swam

My goodness. It felt like just yesterday when I wrote my first President's Forum column for *SMA News* in May 2020. If you search the *SMA News* article archive, I appear in 176 results! These are mostly editorials written during my terms as editor, followed by current presidential columns and lastly, various articles written through the years.

It has been three years. People may not quite realise how much of my time was given towards advocacy for doctors and patients. I tell my friends that I now have 0.5 full-time equivalent (FTE) units for clinical work and 0.5 FTE for administrative work! For the record and for my own accounting, these are some of my achieved milestones over the past few years: I started my private practice; I was elected as SMA President, which led to my appointment in the Multilateral Healthcare Insurance Committee (MHIC); I was subsequently nominated and appointed as a Nominated Member of Parliament (NMP); and then appointed as a member of the Singapore Medical Council (SMC) in July 2022.

My regular engagements included SMA's monthly Council meetings, committee meetings and various networking events, talks and seminars; Parliament sittings, additional briefings by various groups and ministries; and SMC meetings. There were some weeks where I would not see my children for almost the whole week, having only Sundays together.

Was all the sacrifice worth it?

So many things have happened, yet it sometimes feels like nothing has changed. However, one must not lose heart. This is a good time to take stock, take a step back and look at the big picture, and celebrate the many achievements that we have collectively accomplished.

The day-to-day stresses and challenges of the workplace seem to still be ever-present: unhappiness, perceived unfairness in business practices and in insurance empanelment, bullying and harassment from colleagues, from patients, from their families…

Yet, we have made some big, significant steps at the national level:

(1) April 2021: Formation of the MHIC, with the resulting formation of extended panels.

(2) December 2021: Establishment of the National Wellness Committee for Junior Doctors.

(3) March 2023: Minister for Health's affirmation of the Tripartite Workgroup for the Prevention of Abuse and Harassment of Healthcare Workers' findings and recommendations to have a zero-tolerance policy against abuse.

Each of these accomplishments came about due to the combined efforts of many players, and for these to be effective, the players will need to work together and be aligned in their goals. There are a lot more ongoing developments in the private sector, and only time will tell how these developments may roll out.

Step forward, change the future

"I alone cannot change the world, but I can cast a stone across the waters to create many ripples." – Mother Theresa

In my various leadership roles – as SMA President, as an NMP, and as an appointed member of SMC – I have cast many stones. Some sank and some may have broken windows and ruffled feathers, but I hope that some have created a few ripples and inspired others to be leaders and agents of change.

As the world moves towards normalcy and declares that the worst of the pandemic is over, it is a time to rejoice and to appreciate our renewed freedom. But, as I have said before, individuals have short memories.

The public may forget, but the healthcare community cannot afford to. There will be another pandemic and another communicable disease. The profession must endure, and organisations and governments cannot be complacent.

It is not my role to tell others what to do, but this is what the SMA is strong in. The SMA Council has an amazing institutional memory, with archives of newsletters, verbal histories from long-serving members and an incredible network across healthcare and allied health industries.

This issue celebrates the rich history and relationships that SMA has nurtured and developed over the years. I have always asked for more active engagements from our Members, and for more help in recruiting non-Members. The SMA is only as strong as its Members, and we will only get what we put in. No matter how junior you think you are or how young you are, you can be a change leader and an advocate for the groups you care about.

For my final words as President, may I leave you with: "A journey of a thousand miles starts with a single step." ◆

Dr Tan is a mother to three kids, wife to a surgeon; a daughter and a daughter in-law. She trained as a general surgeon, and entered private practice in mid-2019, focusing on breast surgery. She treasures her friends and wishes to have more time for her diverse interests: cooking, eating, music, drawing, writing, photography and comedy.

> ***A journey of a thousand miles starts with a single step.***

Singapore Medical Association

For Doctors, For Patients

SMA Annual Dinner 2023

GUEST OF HONOUR

Dr Vivian Balakrishnan

Minister for Foreign Affairs

22 JULY 2023

Grand Copthorne Waterfront
392 Havelock Rd, Singapore 169663
Grand Ballroom

Cocktails will be served from 6.15 pm

All guests to be seated by 7.15 pm

TICKETS

SMA Members: *$1,900 nett per table*

Non-SMA Members: *$2,200 nett per table*

For enquiries and booking, email Mr Seth Chen at dinner@sma.org.sg.

HIGHLIGHTS

From the Honorary Secretary

Report by Dr Ng Chew Lip

Dr Ng is an ENT consultant in public service. After a day of doctoring and cajoling the kids at home to finish their food, his idea of relaxation is watching a drama serial with his lovely wife and occasionally throwing some paint on a canvas.

Parliament – Committee of Supply 2023 debate

SMA President and Nominated Member of Parliament Dr Tan Yia Swam spoke at the Committee of Supply 2023 debate in Parliament on 3 March 2023.

A video clip of her speech is available online at http://bit.ly/3JunbhR.

AMS-CFPS-SMA Tripartite Dinner

The three professional bodies – Academy of Medicine, Singapore (AMS), College of Family Physicians Singapore (CFPS), and SMA – endeavour to meet twice a year to discuss various issues relating to the healthcare system and professional matters. A dinner meeting hosted by SMA was organised on 16 March 2023. Topics discussed included healthcare insurance, Healthier SG, and the upcoming implementation of ethics core continuing medical education points, among other matters.

The attendees for this meeting were as follows:

AMS	CFPS	SMA
A/Prof Alan Ng *Master*	Adj A/Prof Tan Tze Lee *President*	Dr Ng Chee Kwan *1st Vice President*
Dr Lee Kheng Hock *Scribe*	Dr Wong Tien Hua *Vice-President*	Dr Tammy Chan *2nd Vice President*
Dr Steven Ng *Censor-in-Chief*	Dr Suraj Kumar *Honorary Secretary*	

Share Your Thoughts

What is your take on artificial intelligence (AI) and its increasing integration in medicine? Are you in a field that is tapping on its potential? Or do you perhaps have reservations about it?

Share your observations and experiences with readers and colleagues by submitting your article to **news@sma.org.sg** today!

Further Notes from a *Small Island*

1

Text and photos by Gabriel Kwok

Gabriel reads medicine at Barts and The London School of Medicine and Dentistry. He is Editor on the 28th Executive Committee of SMSUK.

Down the road from the Singapore Medical Society of the United Kingdom's (SMSUK's) editorial office in East London (also known as my bedroom), traditional Cockney mingles with Estuary and Multicultural London English as Received Pronunciation chimes in from the BBC channel. The accents quickly change as we move north into Leicester and the East Midlands, who owe as much to the Angles of Mercia as the Viking Danelaws landing 400 years later. More prosodies emerge as we continue northwards, an incredible array of Northern and Urban West Yorkshire voices catching our ears as we cross Hadrian's Roman walls and the Pennine Hills into Scotland. Meanwhile, across Bristol and Somerset, multiplex versions of West Country English recall both the ancient Celts and the court of Alfred the Great, King of the Anglo-Saxons in the House of Wessex. Great Britain may well be a small island, but her very topography attests to an astonishing tapestry of peoples and traditions, hitherto unknown to us distant observers. Of course, any culture necessarily recalls both triumphs and indignations, presenting a most formidable task for any traveller to navigate. However, since everyone is inevitably shaped by some sort of cultural substrate, not least our future patients, we would still do well to put our best foot forward. Experiencing another culture firsthand, then, must surely rank among our greatest privileges as international medical and dental students.


2

This two-part mini-series of letters from the UK has seen Wildon, Ryan and now Nicholas recount their experiences in Bristol and Leicester, presenting the everyday minutiae which have become so intimately familiar to many of us. Indeed, I still find myself startled by how we have been moulded and challenged through this time abroad, living among people who can be so different from ourselves, while clearly remaining *Singaporean* in our own distinctive ways. Of course, there are at least two, perhaps equally fallacious, temptations to beware here. Uncritically embrace every new idea, and one risks becoming completely untethered from anything substantive, spiralling aimlessly from one non-sequitur to another. Yet, persevere too steadfastly in old assumptions and particulars, no matter how hard-earned, and one may end up with an entirely different kind of disconnect, unable to learn from blind spots and shortcomings. It is truly such a privilege having this time abroad, but this also calls for a certain kind of wisdom: one that can learn from the best of other people without losing sight of the values which have served us well.

It may be helpful to remember that "culture" shares much in common with "coulter", as in "cultivation" or the edge of a farmer's plough – evoking images of both regeneration and furtherance, of a people constantly reshaping topographies in service of one another, while also recognising these things are neither infallible nor immutable. May we learn well as we look to serve our future patients, who may well be very different from us.

Text by Nicholas Lim

It is 9 am on a Thursday. My alarm goes off and I get out of bed. I am instantly greeted by a blast of frigid air, a stark reminder that I am no longer in sunny Singapore. After freshening up and a quick breakfast of cereal and milk (goodbye to S$3 *chai tow kway*), I return to my room and look through the previous week's lectures. At half-twelve (or 12.30 pm, as we might say back home), I make my way to the kitchen again, this time to cook lunch. It is often something easy like pasta or dumpling noodle soup. I am usually done washing up and ready to leave by quarter to two (1.45 pm, not 2.15 pm!).

I step into the -10 °C weather for a leisurely stroll to the university with my housemates. We arrive just in time for the 2 pm lectures – the usual start time for us second-year medics. Our lectures are followed by self-directed group work where we explore clinical and theoretical cases together. My group not only uses the time to work, but to socialise or banter about some dreary lecture that we have had. The lively atmosphere is one of the highlights of my day. It is amid this that I catch a glimpse of the sun setting at around 4.30 pm. Group work ends at 6 pm and we walk back together in the dark. Thankfully, my group mates live nearby.

After getting back, I find myself missing the scents of home again as I cook dinner. The food here tastes a little different, as if missing a certain ingredient. Perhaps it is mum's love (or maybe just MSG). Thursday is laundry day, and I spend some time getting that done. I remember a time before I had a drying rack, when I had to sleep under damp clothes because the dryer was faulty and I had nowhere to hang them – an experience I would not recommend. My housemates have now returned home. They are a lovely bunch, so we often stay up late talking about anything and everything under the sun, bantering or sharing our struggles.

Some weeks, I have placements on Thursdays even though I am still a pre-clinical student. This is actually in a nearby town outside Leicester called Kettering. Kettering's hospital is smaller than Leicester's, but this also means we get more guidance and exposure. I think this will help me build a good foundation for the clinical years. You get the usual spread of patients here – most are extremely helpful and pleasant, but occasionally you do get some grumpier ones, and understandably so. Of course, these are part and parcel of any facet of life and we learn to take them in our stride, as cliched as it sounds.

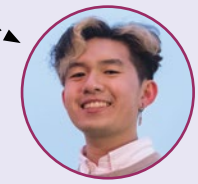
Overall, the pace of life is less hectic here in England and our learning is very self-directed. This gives us more flexibility in managing our day-to-day activities, extracurricular commitments, and responsibilities like grocery shopping, chores, or cooking. This can still get quite overwhelming at times (thank goodness I do not have to deal with taxes yet), but such are the realities of life. I have learnt to look back on the small things and find small moments to celebrate, be it small pockets of me time or chances to meet friends I have not seen in a while. Living overseas has definitely made me more independent and appreciative of the things my parents do for me.

Academics aside, Leicester is also very culturally diverse. It is home to the world's largest Diwali celebrations outside India, testifying to the huge South Asian diaspora here. Unsurprisingly, I am becoming less of a stranger to Bollywood music, which is played at parties from time to time.

On weekends, I try to take the opportunity to travel, since I am already all the way in the UK. My travels have ranged from a short day trip to neighbouring Nottingham, to a weekend getaway in Oslo. It is amazing how much the cityscape can change despite travelling less than an hour away – a refreshing change from the red brick buildings of Leicester. Besides being plenty of fun, these experiences have helped me to widen my horizons.

My past one-and-a-half years have been enriching and have enabled me to grow as a person. I have learnt to be more independent while gaining a newfound appreciation of other cultures, and I would not trade these experiences for anything in the world. ◆

Nicholas is a second-year medical student at the University of Leicester.



Legend

1. SMSUK's weekend trip to Budapest, Hungary

2. Above & Beyond: Unpacking the Future of Medicine, SMSUK's Annual Conference held in London, UK and organised in collaboration with Malaysian Medics International

Singapore Hypertension Society: Beginnings and Purpose

Text and photo by Dr Low Lip Ping

At the 1993 meeting of the Inter-American Society of Hypertension held in San Diego, USA, Morteon Prince suggested the formation of the Pacific Rim Society of Hypertension (PRSH). This suggestion was enthusiastically adopted by representatives of Australia and Japan. Later, in 1994, at the time of the meeting of the International Society of Hypertension (ISH) in Melbourne, Australia, Prof Colin Johnston organised a symposium for potential Asian members. I was one of the Asian physicians at this meeting.

The beginning of the APSH

The first meeting of the proposed PRSH was held in Tokyo, Japan in 1995. I was invited to this meeting where I met Prof Kikuo Arakawa, one of the pioneers in the subsequent setting-up of the Asian Pacific Society of Hypertension (APSH).

The second PRSH meeting was held in Manilla, Phillipines in 1997 and was attended by over 1,000 delegates. After much discussion, it was agreed that an organisation which would span the Pacific Rim – extending from the coast of the North and South American countries to Asia – would be impractical and difficult to maintain. It was decided that this new organisation should concentrate on the Asia-Pacific region. This was also agreed to by the ISH, to which the new organisation would be affiliated.

The APSH was officially established at that meeting in 1997. Members of this society would be the various national societies of hypertension or the hypertension sections of national cardiac societies. I submitted an application to the APSH on behalf of the Singapore Hypertension Society (SHS), which I indicated was in the process of being set up. There was in fact also an application from the Singapore Cardiac Society (SCS) to represent Singapore in the APSH, but I managed to persuade SCS to withdraw their application.

The APSH constitution then provided for an executive council of eight executive members and a secretary general (who was then Prof Trefor Morgan from Australia). Two of the executive members were to represent the founder societies of Japan and Australia, four other members were to represent the societies selected to hold the two following Asian-Pacific Congress of Hypertension (APCH) meetings, and the remaining two members were to be elected by the Council. The president of the society would be the chairman of the next APCH, and the secretariat would be located in Australia.

I was a member of the executive council at its inception and became president in 2001 when we were awarded the honour of hosting the following APCH in 2003.

Forming the SHS

The first APCH meeting was held in Bali, Indonesia in 1999 and the second meeting was held in Pattaya, Thailand in 2001. I represented Singapore on behalf of the soon-to-be-formed SHS

Receiving the flag of the Asian Pacific Society of Hypertension to host the 3rd Asia Pacific Congress of Hypertension in Singapore

and received the APSH flag at the third meeting, indicating that we would be the next APCH host.

I then gathered a group of physicians, including cardiologists, nephrologists, internists and endocrinologists, to form the SHS. We drew up a constitution based on the Registry of Societies guidelines and on the constitutions of other medical societies, including the SCS.

We also designed the logo of the SHS. The two downward arrows forming the "legs" of the letter "h" were modified to represent the desired reduction of systolic and diastolic blood pressure in hypertension. The red colour in the upper half of the arrows represents high blood pressure, while the green colour in the lower half represents low blood pressure.

The registration of the SHS was approved by the Registry of Societies, and we had an official launch of the society at the Pan Pacific Hotel on 23 February 2002. I became the first SHS president, with the late Prof Chia Boon Lock as vice-president. Dr Chee Tek Siong was the honorary secretary and Dr Akira Wu was our honorary treasurer. The initial SHS council members comprised Prof Vernon Oh Min Sen, Dr Terrence Chua, Dr Susan Quek and Dr Wong Kok Seng.

Hosting the APCH

We set about preparing for the third APCH to be held in the second half of 2003. The venue was in Raffles City Convention Centre and if memory serves, we paid a deposit of $50,000 to book the venue.

Then disaster struck in the form of the SARS outbreak in the first half of 2003. As a result, we had only one overseas registrant for the congress. It was obvious that we had to postpone the meeting to 2004. Fortunately, Raffles City allowed us to use the deposit for the postponed meeting.

The third APCH was eventually held in 2004 from 3 April to 7 April. It was a very successful meeting with attendance numbers beyond our expectations, and it also brought us a tidy profit.

Our living history

Over the subsequent years, SHS has continued to play an active role not only in Singapore but also in the Asia-Pacific region. Some years ago, I raised the issue of relocating the head office of APSH outside Australia with Prof Trefor Morgan, particularly as the funds of APSH – held in Australian dollars – were exposed to depreciation. I am glad to share that the secretariat of APSH is about to be relocated to Singapore, following the good work put in by A/Prof Jimmy Teo and Clinical A/Prof Tay Jam Chin. to get the other member societies of APSH to agree to this. I also raised the issue of rotating the position of the secretary general among other APSH members and proposed other changes to the APSH constitution to improve its representation of member countries.

Our society looks set to achieve greater heights in its mission to promote knowledge about hypertension. We invite more members of the healthcare profession, including doctors, nurses and allied health professionals, to become members of the society. It has been a privilege and a pleasure to see the SHS grow to what it has become today. ◆

Dr Low is a consultant cardiologist at Mount Elizabeth Medical Centre and visiting consultant to Singapore General Hospital and the National Heart Centre, Singapore. He is also currently the chairman emeritus of the Singapore Heart Foundation and was a past President of SMA.

The Hot Gallbladder

Text by Dr Lo Hong Yee

Scientific laws are conclusions based on repeated experiments and observations over many years and which have become universally accepted within the scientific community. Some attributes of scientific laws include "true", "simple", "stable", "universal" and "absolute".[1]

Medicine is a science in many ways, but it is peculiar that there are very few laws in medicine.[2] In physics, there are plenty of laws, but there are far fewer in medicine. Medicine abounds with observations. When these observations are replicable and consistent, we call them "evidence". These can then be translated into rules, best practices or standards of care. But few of them endure the test of time to earn themselves the stature of a "law". What was once held as the best or only way to treat a disease can easily be displaced by new observations. And these changes can take place over decades (Halsted radical mastectomy, for example) or just days or weeks! Remember the many rule changes we had to deal with during the COVID-19 pandemic?

New protocols and fresh methods

After retiring from the Singapore Armed Forces, I returned to clinical practice in general surgery. My sojourn in healthcare leadership and management gave me a broader perspective of the landscape, complete with numbers, charts, policies and inventories. Returning to the hospital wards and OTs allows me a closer look at each of those statistics in flesh and blood, literally. What also struck me was how much the practice of surgery has changed within the span of a few years. Previously accepted practices are now frowned upon. For example, inserting central catheters using surface landmarks alone without ultrasound guidance is no longer considered an acceptable standard of care. Performing a rigid sigmoidoscopy prior to haemorrhoidectomy is also no longer routine; I was told that the rigid sigmoidoscope is no longer part of the OT inventory and may soon be consigned to the museum of antiquated surgery as a piece of curiosity from yesteryears. What was once deemed good patient care is being overtaken by advances in technology and new evidence.

Thereby enters the hot gallbladder.

It was before my time, but not that long ago, that cholecystectomy was routinely done through a large, muscle-cutting, subcostal incision. The first laparoscopic cholecystectomy was performed in the 1980s.[3] Soon after, it became the gold standard procedure for cholecystectomy the world over. One question that remained was the timing. There was previously a "rule" for "interval cholecystectomy" (ie, to let the cholecystitis "cool down" and await the abatement of inflammation). Surgeons were to attempt laparoscopic cholecystectomy only after six to eight weeks. About a decade ago, the interval cholecystectomy "rule" was challenged, jeopardising its ascension into a "law".

There was nascent evidence for doing the surgery early within the first 72 hours of symptom onset because the acutely inflamed gallbladder was oedematous, and the oedema would provide a natural dissection plane for the surgeon.[4] The early adopters of this technique were either labelled as "brave" or "foolhardy". Fast-forward ten years, operating on the "hot gall-bladder" during the index admission has become almost a standard of care. Even the 72-hour "rule" did not last very long. While it is still a consideration, it is no longer an absolute prerequisite; patients with up to ten days of symptoms are still being offered

"early laparoscopic cholecystectomy".[5] Another "rule" bit the dust.

Reliable constants

While many of the "rules" and "best practices" have changed in a mere decade, there was also much about clinical practice that has remained constant. When a person does something, it is known as a behaviour. When repeated, it becomes a habit. When many people do the same things, it is called a phenomenon. And when persistent over time, a culture is formed. The scientific part of medicine is supposedly more rigorous, but it can be fickle and can change with time. In contrast, the artistic part of medicine – the culture of the practice in any locale, often dubbed the woolly portion – is more enduring and faithful.

Diligence

One attribute that has remained constant over the years is the diligence of junior doctors. By junior doctors, I refer mainly to the house officers (HOs) but also to the medical officers (MOs), residents and senior residents (aka registrars). Parents of newly minted doctors often mistake a "call" for a "shift", the latter connoting an eight to 12-hour work duration. Junior doctors going on "call" are not exactly working a typical "shift". Strictly speaking, a "call" is more like two to three "shifts" merged into one. Depending on the institution, juniors still do between four to six calls per month, with variations where manpower is adequate, eg, the "float system", "8 am post-call", etc. Apart from calls, the typical workday also starts incredibly early. Despite prevailing rules, juniors often arrive much earlier than me to review the events that transpired overnight, so that senior doctors can have the information at their fingertips during rounds. When I feigned ignorance and asked the HOs what time they arrive at work, I was often greeted with shifty eyes. Don't ask, don't tell? But suffice to say, it is early enough to claim transport allowance via Grab. By 8.30 am, when the rest of the corporate world are just stepping into the office or logging into their first Zoom meetings, our rounds are almost complete and the rest of the clinical activities are in full swing, such as surgeries, endoscopies and clinics.

For generations, juniors have been turning up at work with a spring in their steps and a sparkle in their eyes. One reason is that they never age. The HOs are (almost) always in their mid-twenties. What they lack in experience is more than made up for by their energy, dedication and industry. They also know that things get worse before they get better. There is a finite term to their hardship and many simply grit their teeth and soldier on. Over generations, we have normalised a rather non-physiologically compatible way of working – I struggle to find another industry that sanctions a 24-hour, much less 27- to 30-hour, "shift". While in some professions, occasional bursts of intense work are expected, such as for book closings, deadlines or Army Training Evaluation Centre evaluations,[6] in medicine, these 24- to 30-hour work durations are often sustained for months and even years. I am grateful for the culture of resilience and hard work, but I am also a strong proponent for a more sustainable way of working. Wistfully, I want to have my cake and eat it too.

Learning

Another culture which has not changed is that of teaching, or rather, learning. Besides the formal education sessions (morbidity and mortality conferences, journal clubs, resident teachings, multi-disciplinary meetings, clinico-pathological conferences, etc), one scarcely gets to walk through the hospital without seeing some elements of education going on. It is common to see a senior explaining the syndrome of inappropriate secretion of antidiuretic hormone to the juniors, or the resident scoping under the watchful eyes of his/her consultant, or professors grilling their students. Even the interning student makes an effort to teach the third-year students! Frequently, the education goes in the other direction too: juniors would also be teaching the seniors during ward rounds. The HO who has just completed his posting in general medicine is frequently a great asset to the surgical team. He would teach us the latest on acute myocardial infarction, anticoagulation therapy and even the run-of-the-mill diabetes mellitus and hypertension. In the OT, across the blood-brain barrier, I also eavesdrop on the anaesthetists' banter that takes place while the anaesthesia MOs assist the seniors in administering gas. It is through such interactions that technical know-how, as well as pearls, nuggets and culture about the practice, are transmitted from one generation to another. Lay people often think lowly of the quality of care in teaching hospitals, because of the many junior doctors who are learning. Little do they know that evidence has shown that the quality of care is actually higher in teaching hospitals.[7] The culture of learning is not isolated to junior staff in such an environment. Even seniors, egged on by their juniors or simply pressured to sound intelligent, have to constantly keep up with the latest in medicine!

Why does the culture of learning endure in this environment? Learning is one of the first instincts we acquire. We do not need to be taught how to learn. Just watch a toddler put a square peg into the round hole. He sits there by himself and, without prompting, will eventually learn to put all the

correct pegs into the correct holes. And while there are places where the daily drudgery extinguishes such learning instincts early in one's career, the clinical environment seems to beat the odds. I posit that the students and juniors among us play the crucial role of the "stupid question asker", throwing into disarray long-held beliefs, forcing seniors to rethink, go back to the drawing board and continue learning. That is possibly the secret sauce for a thriving culture of learning.

Kindness

The last aspect which has remained constant is kindness, both to patients and colleagues. In public hospitals (aka restructured hospitals), the bulk of the patient load comes from a segment of society who may not necessarily be paupers, but are certainly not well heeled. People who choose to work in medicine are self-selected. There is a tendency to want to help, to relieve and to comfort. In public hospitals particularly, where clinicians are somewhat shielded from the financial aspects of the practice, I continue to witness much kindness in the way doctors treat and communicate with patients and their families, regardless of their ability to pay. While clinicians have to treat both "private" and "subsidised" patients in the course of their work, the resource allocation and triaging considerations are based on disease acuity, rather than on "ward classes". This ranges from CT scan priority, ICU admissions and even the time spent by the patients' bedside or with their families, explaining the disease and treatment plans. It is subjective, but from my vantage point observing colleagues, I also do not see a difference in the degree of "nice-ness" whether the patient is in an A class or C class ward. In fact, it is often the C class ward *Ah Pek* or *Makcik*, the illiterate but sweet, endearing (and unfortunately, long-staying) patients who are the most doted on.

Kindness to colleagues is another constant and understated attribute in the practice. I am heartened by how stronger HOs would cover for the weaker ones, especially for the junior staff embarking on their first year of practice. It is after all a bell-shaped population, but unlike in the corporate world, I see in the juniors this generous spirit which I hope will carry on for the rest of their careers. It is common to see stronger HOs voluntarily do more "changes", stay back or turn up "furtively" even when on their scheduled off-days.

It is also a culture of "step down" kindness. At every level, whenever the work gets overwhelming, the higher-level colleagues would roll up their sleeves to help. MOs, sacrificing their rest time or precious OT time, come to help the HOs. Registrars/senior residents chipping in to help run busy clinics. I once saw a HO volunteering to help a weaker colleague with the menial task of obtaining a blood gas sample. Not wanting to make a big deal out of it, the HO gave the excuse that it was for accruing more hands-on experience with arterial blood sampling. This and multiple other anecdotes peppered my return journey to the clinical environment, giving me much optimism that despite the rapid changes in the science of healthcare, kindness in the art of medicine remains constant.

Final thoughts

Plunging back to clinical practice was exhilarating in many ways and for my first few months, I did not have the time to reflect on my patients, colleagues and the practice (read: too tired, cannot think!). The hot gallbladder triggered me to share some of my thoughts which I hope will resonate with colleagues who are currently in the practice or, at least, who have gone through the system. I have also noted a few other interesting observations, such as the disappearing art of the gridiron access,[8] over the span of a mere few years. But that will be a story for another day, the tale of a cute appendix. ◆

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Dr Lo is a general surgeon at Tan Tock Seng Hospital. Previously, he was the Chief of Medical Corps at the Singapore Armed Forces. He has high regards for house officers and enjoys jogging at Bukit Brown. He lives in Sengkang with his wife.

Singapore Medical Association

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Reflections on Our Journey with the Geriatric Surgical Service

Text by Jessica Wong, Sarah Chan and Wymann Tang

For our Year 4 electives, we signed up for the Geriatric Surgical Service (GSS) elective, which was part of the Learning Oriented Teaching in Transdisciplinary Education (LOTTE) programme at Khoo Teck Puat Hospital (KTPH). Through exposure to general surgery, geriatrics and other disciplines, we had the chance to appreciate the value of transdisciplinary, patient-centric care.

The GSS in KTPH was first established in 2007, with the aim of developing more holistic care for elderly patients undergoing surgery. It was recognised that this subset of patients had more complex needs that could not be managed by merely one physician but required the assistance and input of multiple disciplines. They also often had more individualised goals that needed to be carefully discussed for their care. The GSS hence aims to bring together various members of the healthcare team (such as the general surgeon, geriatrician, nurse, anaesthetist, cardiologist, dietitian and physiotherapist), to work together in caring for geriatric surgical patients. While the idea of multidisciplinary care is not new, it may result in fragmentation of care when different disciplines work separately. The GSS was borne out of the hypothesis that a model with one dedicated transdisciplinary team, working together and committed to patients' goals of care, would produce better healthcare outcomes.

The journey begins

On the first day of our posting, we joined a family conference with a general surgeon and a geriatrician, as well as the patient Mr T and his family. Mr T was an elderly nursing home resident presenting with impending intestinal obstruction secondary to a colorectal tumour. The case was a complex one, as Mr T had significant comorbidities and was cognitively impaired. A clinical decision for "Do Not Resuscitate" had been made previously. There were many considerations regarding the next steps in his management – Mr T's comorbidities, poor baseline function and the new problem of a cancer with impending obstruction needed to be put into context. We saw how both the surgeon and geriatrician constantly brought the focus of the conversation back to Mr T and his goals of care. Mr T enjoyed eating good food, and that never failed to bring him joy. With that in mind, the decision was ultimately made for him to undergo a surgical procedure with the primary goal of allowing him to be able to eat without performing any overly invasive intervention. This was to be achieved with a diverting loop colostomy for symptomatic relief of the intestinal obstruction. The family conference set the tone for our elective – the holistic, transdisciplinary nature of care which was centred upon the patient and his/her goals of care.

We had a multifaceted experience over the course of this elective posting. In addition to attaching ourselves to transdisciplinary ward rounds, clinics and the OT, we had opportunities to follow the specialty and advanced practice nurses in doing the geriatric assessments for patients, and to sit in on team meetings involving the dietician, physiotherapist and case manager in evaluating their respective care goals and needs for the patient.

We also spent time speaking with the patients before and after their surgery. Besides gaining a keener understanding on their symptoms and post-operative concerns, we learnt a great deal about their unique and individual life stories as well. This collective experience embodied the spirit of the GSS ideology of journeying with the patient "from start to finish", which enabled us to better empathise with the patient's experience holistically at various time points as well as to further our understanding of the perspectives of our allied healthcare team members.

Frailty was a new concept we grew to appreciate during our elective; the reduced functional reserves an elderly patient has leaves him/her more vulnerable to insults. While many of us were familiar with the concept of post-operative rehabilitation, our mentors introduced us to the concept of "prehabilitation" – optimising a patient's functional status pre-operatively. We saw how an individualised prehabilitation programme to improve a patient's functional reserves could make such a profound difference in the post-surgery outcome. As we journeyed with our patients and reflected on some of their pre-operative and intra-operative considerations, our mentors constantly reminded us that the goal of simply reducing the mortality and morbidity of the peri-operative journey was inadequate. What was even more important was to empower patients to lead meaningful lives even after surgery.

During our time with the GSS, we also realised first-hand the improvements a transdisciplinary model of care has made to current standards of multidisciplinary care. This was demonstrated to us in numerous ways, from the collaborative approach in engaging a patient's family, to seeing a surgeon perform geriatric assessments, and sitting in on team meetings involving allied health professionals collaborating to form a comprehensive picture of the patient's care needs. It was impressed upon us that the dissolution of silos between disciplines is pivotal in providing integrated unfragmented care, while reducing ambiguities and points of inefficiencies. On a meta level, this also means that the patient can truly be cared for as a unique individual, as opposed to a loose collection of medical and surgical issues to be addressed separately by different specialists. In other words, a transdisciplinary model enables the delivery of a more humanistic form of care, with the patient at its centre.

The many lessons learnt

The primary focus of our training as students has been to build a foundation of medical knowledge, amass clinical experience, and refine our clinical acumen and reasoning skills. Experiencing an elective posting with the GSS, however, has shown us the value of going beyond developing our skills as future doctors, to examining and rethinking the processes in the provision of care for patients.

From understanding the philosophy and growth behind the GSS, we learnt the importance of thinking from the perspective of the patient in his/her journey within the healthcare system, identifying unmet needs and potential solutions from the systems level. Re-engineering the patient's journey from the reorganisation of logistics and resources can also go a long way in improving outcomes for the patient. Even at the time of our posting, we were heartened by the efforts of the GSS team in furthering knowledge to improve current protocols, such as the identification of sarcopenia among patients as a prognostic factor for surgery, allowing for a more informed decision in proceeding with surgical treatment.

Our time with the GSS has challenged our perspectives on the way care should be provided for our patients. The unit's outcomes are a testament to what can be achieved by putting the patient first. As students, we are deeply encouraged to apply these lessons in our future practice.

Acknowledgements

We would like to express our heartfelt gratitude to A/Prof Tan Kok Yang, Dr Daniel Lee, Dr Priscilla Ng, the transdisciplinary team at the GSS, the LOTTE programme, as well as every patient we have encountered in our short elective journey for this very fruitful learning experience. ◆

Jessica is a medical student who just graduated from the National University of Singapore (NUS) who enjoys drinking tea and being a book nerd in her free time.

Sarah is a medical student who just graduated from NUS. She finds joy in building meaningful relationships with and journeying with patients in the long term. Beyond medicine, she enjoys running through nature trails and rock climbing.

Wymann is a medical student who just graduated from NUS. He is a fan of *Star Wars* and enjoys playing basketball recreationally in his free time.

Digital Resources to support Healthier SG

By Agency for Integrated Care

Digitalisation is key for Healthier SG, and participating clinics will need to use a Healthier SG-enabled Clinic Management System (CMS) to better monitor patients' care outcomes effectively and carry out the required Healthier SG care reporting.

Healthier SG clinics will need to use a Healthier SG-compatible CMS within 1 year from Healthier SG enrolment launch and:

- **Apply for National Electronic Health Record (NEHR) view-access for practicing doctors**
- **Contribute to NEHR**

About the NEHR

The National Electronic Health Record (NEHR) is a single patient health record which collects summary patient health records across different healthcare providers. Since patients typically visit multiple healthcare providers throughout their lives, each provider may have separate information about the same patients. The NEHR enables authorised healthcare professionals to have a longitudinal view of their patients' healthcare history and helps them make better informed diagnosis and treatment decisions.

To apply for NEHR access or find out more about the Early Contribution Incentive (ECI), please scan this QR code.

Do apply for the ECI as soon as possible as the application will close on 30 June 2023.

With Healthier SG being a key priority, private and public healthcare professionals across settings will need to connect and collaborate to provide more coordinated care for enrolled patients. Technology and data will be crucial and the NEHR will be a key enabler for Healthier SG as it will allow providers to contribute and have access to patients' medical records, which will give them a better picture of patients' health and allow them to work more closely with community partners in the provision of care.

NEHR Early Contribution Incentive (ECI)

The ECI was developed to support private healthcare licensees by providing a one-time grant to help defray the cost of upgrading and/or integrating their clinic management systems with the NEHR. All GP licensees are eligible for this grant of $2,400 and are entitled to receive the ECI only once. Licensees who offer multiple healthcare services may be eligible for a separate ECI amount if the healthcare services are offered under separate entities.

Pre-requisites for Data Contribution under the ECI

1. **Your IT solution needs to be integrated with the NEHR**
2. **Your clinic needs to be approved by MOH for NEHR participation**
3. **You need to validate and ensure quality data is being contributed to NEHR**

Disbursement of the ECI

The ECI will be disbursed upon completion and contribution of all relevant data types and meet quality data criteria for a consecutive period of three months over a sixth-month period. The demonstration window for this will be from December 2022 to end June 2024.

GP IT Enablement Grant

Besides the ECI, there will be a once-off GP IT Enablement grant to support GPs in the digitalisation and adoption of a Healthier SG-compatible CMS.

In addition to being approved to contribute data to NEHR, a Healthier SG-compatible CMS will need to:

- **Be certified by a third-party assessor that baseline cybersecurity requirements have been fulfilled.**
- **Be integrated with Healthier SG web-services such as enrolment and care reporting, as well as web services for existing core GP schemes.**
- **Have fulfilled data portability standards.**

GP licensees who have received the ECI or who have already onboarded a Healthier SG-compatible CMS prior to the launch of Healthier SG will still be eligible for the GP IT Enablement Grant. The application window for the GP IT Enablement Grant will be from 1 July 2023 and 30 June 2024. More details will be available on www.primarycarepages.sg closer to the launch date.

A CMS Tiering Framework for Primary Care has been developed in order to monitor the scope of requirements of the various CMS. This tiering will be updated progressively to incorporate additional CMS features as requirements evolve.

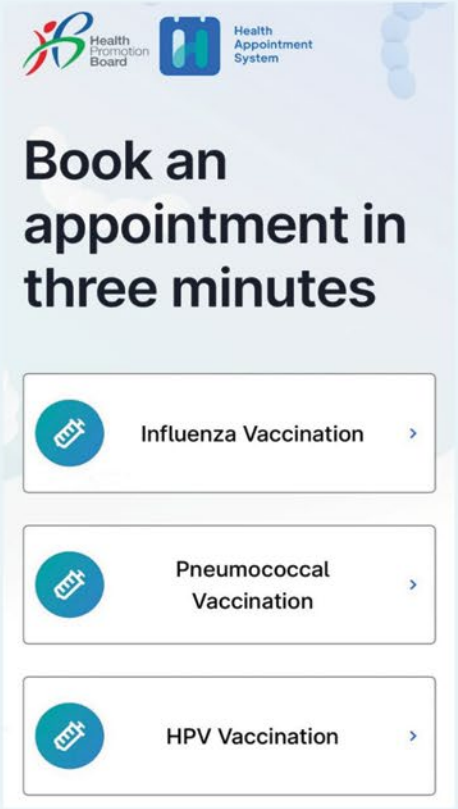
For more information about the CMS Tiering framework for Primary Care & the Healthier SG Adoption Progress Status for CMS Providers

Please scan this QR code:

If you are thinking of adopting or switching to a CMS that is more suited to your needs, please visit the AIC Primary Care Pages for a Guide to a Healthier SG-compatible CMS.

Health Appointment System (HAS)

HAS was developed by Open Government Products (OGP) to facilitate appointment booking at GP clinics for national schemes.



From 5 July 2023, residents enrolled with HAS clinics will be able to select their appointment date and time in HealthHub, which has a seamless backend interface with HAS, to schedule their Healthier SG First Consultation appointment.

After the appointment has been made, residents will receive an SMS confirmation, as well as an SMS reminder on the day of the appointment.

Sign up for HAS at go.gov.sg/register-clinic

Flamenco: With Passion and Mission

Text by Dr Daphne Huang

Throughout my medical student life, I loved to dance but never really got around to it in any serious fashion, partly due to the rigours of studying for my medical specialist degree. Medical officer days in my time were tough too – we did calls that usually had no post-call day off, and when we returned home after two days working in the hospital, we would often crash out like a dead log. Combined with my spare time spent studying for examinations, I hardly had time to take dance classes.

My first dance steps

All that changed one day when I decided not to pursue a specialist path anymore, much to the dismay of my medical tutors at that time. Not needing to spend my free time studying, I decided to pursue a hobby. I signed up for various dance classes that included genres such as Argentinian tango, Latin ballroom and salsa. One day, I stumbled upon an article about flamenco dancing. At the time, my unworldly and ignorant self had not encountered this word before, and so I was extremely curious about it. It was described in a magazine as a highly passionate, expressive and evocative dance form from Spain, with its origins associated with gypsies. My curiosity was piqued.

I found that this dance form was very different from anything I had done before. It required a combination of arm work, postures, turns, marking steps to the music and songs, and footwork technique for rhythm. As flamenco is a live art form with the traditional trifecta of song, guitar and dance, I had to learn the different *palos* or dance/music forms that were different from one another, each with its own unique style, rhythm, mood and songs. Later, I also had to learn how to communicate with live musicians in a dance piece. It was definitely a steep learning curve, but the more I danced, the more intrigued I became.

The path forward was by no means easy as I had no prior dance background or training. Dancing wildly in clubs, fuelled by alcohol in my blood, certainly did not count. What drew me especially was that flamenco required you to express yourself individually, to be your own person, and that it did not conform to the usual "standards" of body shapes and types. You could also dance it well into your 50s and 60s. I saw people big and small, tall and short, old and young, all performing flamenco at a very high level. After a while, I was certainly hooked.

Photo: Andy Tan

Singapore Flamenco Festival 2016
Misa Flamenca

Photo: Alan Ng

Singapore Flamenco Festival 2022
Flemenco Puro

Flamenco Sin Fronteras

Later, I met and married a flamenco maestro and he moved to Singapore to be with me. We now have two teenage children. Flamenco was an extremely niche art form at the time and very few people knew about it. It was not easy trying to set up a flamenco school or company and undertake arts productions.

I had to learn the ropes from scratch and slowly, we began to build a flamenco community in Singapore. We decided to take the plunge and opened a non-profit arts company Flamenco Sin Fronteras in late 2011. In 2013, we started producing theatrical flamenco productions and have not looked back since. Ten years later, we are now recognised as a serious arts group in Singapore, contributing to the local arts scene, collaborating with other renowned Singaporean artistes, and crossing borders and boundaries with our art form. Some of our past productions include *Misa Flamenca* (a choral work with flamenco), *Elements* (flamenco with Chinese cultural influences), *Amor Ratii* (*Kathak* Indian dance mixed with flamenco), and *The House* (a flamenco dance drama). We also became part of the National Arts Council-Arts Education Programme and have introduced flamenco to mainstream schools all over Singapore.

Helping those in need

We also started doing flamenco in the community. We have been part of the Silver Arts initiative by the National Arts Council, and we have been working with low-income elderly, at-risk children from low income or single-parent families, and the Singapore Association for Mental Health. I have a great sense of pride and satisfaction when I see how flamenco can help our vulnerable communities.

Flamenco requires the coordination of arms, feet, head and body, all moving at the same time with much wrist movement that helps to loosen stiff joints. One also needs to understand rhythms and be able to express emotions of the dance – sadness, happiness, flirting, etc. It also empowers individuals, especially women, as flamenco dancers can be seen as being strong – one does not need a male partner and can dance it at any age. Many of the elderly ladies

Photo: Flamenco Sin Fronteras

La Fiesta 2022

I teach would say to me: "To be able to coordinate, remember and dance my routine definitely helps to prevent dementia!"

Our group works actively with Social Health Growth, and I have been teaching flamenco to a group of Chinese-dialect-speaking matured women in low-income areas for the last three to four years. We adapted to their age with moves that are gentle on the knees and even turned some *jaleo* lyrics in our dance into Hokkien and Malay.

These students were initially lacking in coordination and were too shy to perform in front of the public, needing me to dance with them. Now, they have progressed to putting up mini dance dramas (they acted as *Samsui* women in December), co-creating parts of the performance, and can dance independently. They have their own dance social groups, meeting regularly as flamenco has become part of their "health dance".

I believe that flamenco has helped to give them purpose – something to look forward to and to bond socially with fellow dance mates. I once titled their item "*Ah Ma* can dance *bulerias*, and so can you!" Many of these ladies are aged between 60 and 70, with a few nearing 80. It certainly stimulates them physically and mentally, and I love how they enjoy themselves thoroughly each time. Laughter is certainly the best medicine.

A particularly memorable case was that of a cute grandma in her late 70s. She had fallen and sustained a vertebral compression about two years ago and was initially wheelchair-bound. She wanted so much to be back with her friends that, with absolute determination, she pushed herself a bit more each time, and is now able to climb up the stairs to the second storey for our dance classes.

Final thoughts

Due to my work in Flamenco Sin Fronteras where I perform and teach, I now practise medicine as a part-time locum – mainly as a doctor in nursing homes. I feel that my artistic work in the community adds another dimension to my work as a doctor, though I perform them in different capacities.

Looking back, I know that if I had pursued a full medical career, I might not have pursued flamenco. Growing up, I certainly never expected myself to have a career in the arts either. That would have been absurd to me at that time. The decisions you make in life certainly do throw unexpected curveballs in your path. Now that I have a family and an arts company, I continue to grow and practise my work as a GP – I certainly have no regrets. ◆

Dr Huang is a GP who locums in nursing homes. She is also a founding member, teacher and artiste with Flamenco Sin Fronteras, a non-profit arts company in Singapore.

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Mt Elizabeth Orchard Clinic for Sale. 782 sq ft. Mt Elizabeth Hospital is undergoing major redevelopment at present. Strata title will be extended to 99 years in the near future. Please call or WhatsApp James: 8338 9240.

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TESTIMONIAL FROM DR CK TAN
Prunella puts us at ease the moment we met her. She is very knowledgeable about tenancy in clinics.

INSTITUTE of MENTAL HEALTH
National Healthcare Group

Resident Physician (Ward-based)

The Institute of Mental Health (IMH) is a 2,000-bed acute tertiary psychiatric hospital situated at Buangkok Green Medical Park that offers a comprehensive range of psychiatric, rehabilitative and counselling services for children, adolescents, adults and the elderly. IMH also plays a key role in training the next generation of mental health professionals in Singapore through collaborations with the local tertiary institutions.

Job Responsibilities

- Be part of the broad-based care team responsible for the management of psychiatric patients in the following areas:
  - o Addiction Medicine
  - o Emergency Services
  - o Recovery Care
- Perform any other duties instructed by Specialist-in-Charge or Head of Department

Requirements

- Possesses MBBS registrable with the Singapore Medical Council
- Preferably possesses MMED or Postgraduate qualifications in Internal/Family/General Medicine or Psychiatry. Those with relevant training and experience will be considered for senior positions.
- Has worked in psychiatric inpatient setting
- Has at least 5 years of post-housemanship experience

Full time/Part time/Contract terms available

Interested applicants may submit their applications to:
careers@imh.com.sg

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Resident Physicians

Ang Mo Kio - Thye Hua Kwan Hospital is a patient-centric community hospital providing rehabilitative and sub-acute care. Our multi-disciplinary healthcare team develops a personalised and comprehensive programme for each patient to enhance their recovery. Our aim is to help patients achieve good clinical outcomes and assist them in their integration back into society after discharge.

Description:

You will provide first-line clinical coverage, handle more complex cases with the supervision of senior doctors, and guide the junior doctors accordingly. You will assist with ward rounds and provide medical consultation, perform ward procedures, stay-in night duties, and other duties as assigned by your supervisor.

Requirements:

- Possess a basic medical degree or postgraduate qualification that is registrable with the Singapore Medical Council
- Eligible for Conditional or Full registration with the Singapore Medical Council
- Possess at least 3 years of post housemanship working experience as a medical officer (or equivalent) in the relevant discipline
- In active clinical practice
- A team player with a passion to care for the elderly
- Possess good interpersonal and communication skills
- Interest in geriatric medicine, rehabilitation medicine or family medicine would be advantageous

Interested applicants may submit your full resume to **career@amkh.org.sg**

NYP NANYANG
THE INNOVATIVE POLYTECHNIC

Nanyang Polytechnic (NYP) is a premier tertiary institution committed to providing quality education and training with strong industry and international linkages to prepare students and adult learners for work and life. We place strong emphasis on developing our people and building their careers with NYP.

LECTURER IN MEDICAL SCIENCE

- You will be working in the School of Health & Social Sciences to plan, develop and teach basic medical science modules such as anatomy, physiology, pharmacology and pathophysiology
- As a Lecturer you are expected to be familiar and use the latest pedagogical techniques in the delivery of lectures, tutorials and practicals
- You are also required to undertake assigned student mentoring, course promotion, administrative and committee duties and be involved in quality teams
- You may also need to supervise student projects

JOB REQUIREMENTS

- MBBS with 3 years of relevant working experience in hospital setting as a medical officer

If you share our vision in building a premier polytechnic of global distinction and are dynamic, innovative, highly resourceful and self-motivated, we invite you to join us.

For more details and application, please log on to **Careers@Gov** at **https://tinyurl.com/NYPCareersMed-Science**

HKU Med LKS Faculty of Medicine
The University of Hong Kong
香港大學李嘉誠醫學院

RECRUITMENT

The LKS Faculty of Medicine of the University of Hong Kong (HKUMed), being one of the top medical schools in Asia and in the world, is now seeking seasoned clinical practitioners **in all medical disciplines** to join our professoriate team.

You should have a sustained record of excellence in one or more of the following areas:
(i) Clinical Services
(ii) Teaching and Learning
(iii) Knowledge Exchange and Services
(iv) Research (basic science, translational and/or clinical research)

You should process a medical qualification with demonstrated post-qualification clinical experience, and a specialist qualification in the relevant discipline. Applicants without specialist qualifications may be considered on a case-by-case basis.

HKUMed offers a highly competitive salary commensurate with qualifications and experience. The **mid-point of the basic salary range** of our clinical professoriate at different ranks are as follows:

- Clinical Assistant Professor: ~USD13,000 per month
- Clinical Associate Professor: ~USD20,000 per month
- Clinical Professor: ~USD25,000 per month

You may be able to obtain full medical registration in Hong Kong without the need to undergo local licensing examinations after working with us for at least 5 years under the new regulatory regime of the HKSAR Government.

Please contact HKU Health System at **hkuhs@hku.hk** for further information.

NATIONAL SKIN CENTRE
National Healthcare Group

National Skin Centre (NSC) is a tertiary dermatological centre with a team of dermatologists who have the experience and expertise to treat a wide range of skin conditions including patients with complex care needs. With a comprehensive range of subspecialty services, NSC sees a patient load of about 1,000 daily for consultations and treatment. Apart from providing clinical services, NSC is the main training centre for specialist training, undergraduate and post graduate dermatology training and has an active clinical and translational research programme in dermatology.

We are currently seeking suitable candidates for the position of :

Resident Physician

You will be working closely with the senior medical staff, to provide clinical care and medical treatment to patients. You will be responsible for the running of the outpatient clinics and the care of both new and follow-up patients seen at NSC and Department of Sexually Transmitted Infections Control (DSC) clinics as well as providing on-call duties at the inpatient dermatology ward when necessary. You will be guided by specialists to adhere to the Centre's management guidelines at the clinics.

Requirements:

- Basic medical qualification registrable with Singapore Medical Council
- Possess a valid practising certificate, full or conditional from the Singapore Medical Council
- Postgraduate medical qualifications (MRCP or Graduate Diploma in Family Practice Dermatology) will be an advantage

If you wish to be part of a challenging yet exciting medical team, please apply through the Careers page at **www.nsc.com.sg**.

We regret that only shortlisted candidates will be notified.

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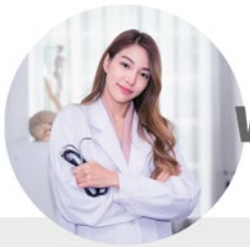

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PEDIATRICIAN PARTNERS

We are looking for **pediatrician partners** to join us. Terms of partnership are open to discussion.

Locations

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"As General Practitioners, we are at the front-line for patients to seek help for a myriad of conditions. Some of my regular patients do come in for mental health issues. For that, we need to better equip ourselves to manage such conditions within the primary care setting. Being equipped to diagnose and manage psychiatric conditions through the GDMH programme gives me the confidence to care for these patients who may have complex medical and mental illnesses."

– **Dr Jonathan Yeo** [pictured],
Family Physician, GDMH Cohort 11 graduate.

GRADUATE DIPLOMA **IN MENTAL HEALTH**

Mental Health Course for General Practitioners and Family Physicians

In Singapore, one in seven people has experienced a mental health condition in their lifetime. Yet, majority (more than 75%) did not seek professional help. This could be due to a lack of understanding or poor recognition of the symptoms. Doctors in primary care – General Practitioners (GPs) and Family Physicians (FPs) – therefore play a significant role as the first line of care, to detect and intervene early.

The **Graduate Diploma in Mental Health (GDMH)** is jointly offered by IMH and the Division of Graduate Medical Studies, National University of Singapore. The course, into its 13th year and conducted by mental health specialists, aims to enhance the knowledge and skills of GPs and FPs to assess, identify and manage various psychiatric conditions in the community.

Participants will learn more about:

- ☑ Identifying and diagnosing common psychiatric disorders;
- ☑ The principles of different treatment approaches;
- ☑ Applying assessment methodology to different mental health disorders; and
- ☑ Managing and prescribing basic psychiatric medications.

Registration for 2023/2024 intake opens 27 Mar – 3 Jul 2023

80%* course fee subsidy from MOH for eligible applicants who complete the course. 50 core CME points upon completion of the course.
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Contact Us

Shuhui @ **6389 2263**
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GDMH@imh.com.sg

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